STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 01 B. WING	06/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCGIVNEY HEALTH CARE CENTER	2907 E 136TH ST CARMEL, IN 46033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/26/13 Facility Number: 000545 Provider Number: 15E594 AIM Number: 100267350 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, McGivney Health Care Center was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire	K010000	Disclaimer : Preparation, Submission and Implemenation of this Plan of Correction does not constitute an admission of/ or agreement with the findings of this survey. McGivney Health- care reserves the right to contest the survey findings through the informal dispute resolution, formal appeal pro-ceedings or any administrative or legal proceedings. The facility offers its responses, credible allegations of compliance, and plan of correction as part of ongoing efforts to provide quality care. McGivney Healthcare Care Center reserves the right to modify policies, procedures, and quality improvement systems as necessary to better meet the needs of the residents and facility.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	alarm system installed in all resident sleeping rooms. The facility has a capacity of 37 and had a census of 34 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached storage buildings providing facility services which was not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/13. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. Based on observation and interview, the facility failed to ensure 1 of 2 doors in a stair enclosure was self closing in accordance with Section 19.3.1.2. This deficient practice could affect 8 residents, staff and visitors in the vicinity of the stairwell on the lower level. Findings include: Based on observations with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, the lower level stairwell door which was held open by a magnetic device did not self close and latch into the frame when the door was manually released five separate times. The lower portion of the door abuts the frame which prevented the door from closing and latching into the door frame. In addition, the aforementioned door failed to completely self close and latch into the door frame when the fire alarm system was activated at 1:04 p.m. on 06/26/13. Based on interview at the time of the observations, the Director of	K010020	1. The Lower Level Stairway door was repaired to close all the way into frame and latch. 2. All residents have the potential to be affected by the deficient practice. 3. Doors will be checked Quarterly during FireDrills. Staff in-serviced on citation 07/12/2013. 4. Results will be taken to QA x3 Months, and Quarterly thereafter until deemedunnecessary by the Medical Director and or IDT Team. 5. DOC: 07/26/2013	07/26/2013

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	Facilities and Property Management acknowledged the lower level stairwell failed to self close and latch into the door frame. 3.1-19(b)			

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K010029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 9 doors serving hazardous areas such as fuel fired heater rooms was self closing and would latch into the door frame. This deficient practice could affect 22 residents, staff and visitors in the vicinity of the furnace room by Room 16. Findings include: Based on observation with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, the furnace room by Room 16 contains one natural gas fired furnace and the entry door is not provided with a self closing device. Based on interview at the time of observation, the Director of Facilities and Property Management acknowledged the aforementioned hazardous area is not	K010029	1. Door assessed by Regional Maintenance Director and repaired with replacement spring loaded door hinges to replace broken spring loaded hinges. 06/26/2013 2. All residents/ visitors have the potential to be affected by this deficient practice. 3. Door will be checked by Maintenance weekly to ensure safety compliance. Staff in-serviced on citation 07/12/2013. 4. Results to QA monthly x 6 months and Quarterly thereafteruntil deemed unnecessary by the Medical Director and or IDT Team. 5. DOC: 07/26/2013	07/26/2013

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	provided with a self closing device on the entry door to the room. 3.1-19(b)			

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K010046 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 16 of 16 battery powered lights for 12 months. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents staff and visitors. Findings include: Based on review of "Monthly Testing Fire Extinguisher/Exit Light System" for 2012 and "Monthly E-Light/Extinguisher Checks for Year 2013" with the Executive Director and the Director of Facilities and Property Management during record review from 9:40 a.m. to 11:50 a.m. on 06/26/13, documentation of functional testing at 30 day intervals for 30 seconds for each of 16 battery powered emergency lights in the facility for the most recent twelve month period was not available for	K010046	1. Monthly Functional Testing Form was updated to reflect 30 second monthly test and 90 minute annual test. 06/28/2013 2. All residents / vistors have the potential to be affected by this deficient practice. 3. Maintenance will perform check monthly to ensure 30 Second Monthly Test is completed, including using updated form with correct language of 30 second monthly test and 90 minute annual test. Executive Director will request form randomly to check for compliance. Staff in-serviced on citation 07/12/2013. 4. Results will be taken to QA monthly x 6 Months and Quarterly thereafter or until Medical Director / IDT Team deems unnecessary. 5. DOC: 07/26/2013	07/26/2013

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	review. Based on interview at the time of record review, the Director of Facilities and Property Management stated the aforementioned documentation is a monthly record of functional testing, but not for thirty seconds and acknowledged functional testing documentation at 30 day intervals for 30 seconds for each of 16 battery powered emergency lights in the facility for the most recent twelve month period was not available for review. Based on observations with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, each of the 16 battery powered emergency lights in the facility illuminated when their respective test button was pushed. 3.1-19(b)			

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K010050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to document fire drills conducted on the second shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Drill/Alarm Record" documentation with the Executive Director during record review from 9:40 a.m. to 11:50 a.m. on 06/26/13, documentation for the second shift fire drill conducted in the third quarter 2012 on 08/30/12 did not include the time of day the fire drill was conducted. The aforementioned fire drill report stated "Shift, second" but documentation of the time of day the fire drill was conducted was not available for review. Based on interview at the time of record review, the Executive Director acknowledged documentation of the time of day the	K010050	1. The fire drill on 8/30/2012 was completed, time cannot be determined since Executive Director and Maintenance Staff are no longer employed. 2. Staff, Residents, and Visitors have the potential to be affected on this deficient practice. 3. Fire Drills will be conducted on each shift at least quarterly. Executive Director will review Fire Drill Documentation to ensure shift and time are recorded. Regional Maintenance will review documentation upon visits to facility. Staff in- serviced on citation 07/12/2013 4. Results to QA x 6 months and Quarterly thereafter or until deemed unnecessary by the Medical Director and or IDT Team. 5. DOC : 07/26/2013	07/26/2013

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	aforementioned fire drill was conducted was not available for review. 3.1-19(b)			

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K010062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to replace 1 of 2 sprinklers in the oxygen storage and transfilling room which had been painted. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, the automatic sprinkler attached to the four inch diameter sprinkler pipe in the oxygen storage and transfilling room had paint on the deflector. Based on interview at the	K010062	1. Removed drywall componet from Sprinkler Head and Cleaned. 7/8/2013 2. All residents, Vistors and Staff have the potential to be affected by this deficient practice. 3. Weekly rounds will be conducted by Designee to check for any for foreign material on sprinklers. Regional Maintenance Director to check sprinklers randomly during facility visits. Any sprinkler found to be questionable, facility will contact outside professionals to inspect and repair as needed. Staff in-serviced on citation 07/13/2013 4. Results to QA x 6 months and Quarterly thereafter until Medical Director / IDT deem unnecessary. 5. DOC : 07/26/2013	07/26/2013

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	time of observation, the Director of Facilities and Property Management acknowledged the aforementioned automatic sprinkler in the oxygen storage and transfilling room had paint on the deflector. 3.1-19(b)			

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K010076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction and separated by a minimum distance of at least five feet from combustible materials. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Director	K010076	1. Liquid Oxygen Removed. Relocated Liquid Oxygen to a outside storage area in a flameable cabinet with a locking door and proper signage. 2. All residents,vistors, and staff have the potential to be affected by this deficient practice. 3. Nursing Staff will check outside flameable cabinet after filling 02 portable tanks. Upon hire of maintenance oxygen / cabinet will check weekly during walking rounds. Executive Director will check Medication Room Quarterly to ensure no Oxygen Unit is stored. Oxygen Vendor will be instructed to leave no Oxygen in Medicication Room and to place into new cabinet outside on cement patio. Facility will maintain Oxygen Cylinders to be 3,000 cubic feet or less. Regional Maintenance Director will check for compliance upon visits to facility. Staff inserviced on citation 07/12/20134. Results to QA	07/26/2013

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	of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, the entry door to the oxygen storage and transfilling room by the Nurses Station had an affixed label stating it had a 20 minute fire resistance rating. In addition, one liquid oxygen storage container which was three quarters full was observed stored in the room and two plastic storage containers were on the floor of the oxygen storage and transfilling room three feet from the liquid oxygen storage container. Based on interview at the time of the observations, the Director of Facilities and Property Management stated the entry door had less than a 45 minute fire resistance rating and the ceiling of the oxygen storage and transfilling room had less than a one hour fire resistance rating, and acknowledged the oxygen storage and transfilling room did not provide separation of at least one hour fire resistive construction. In addition, the Director of Facilities and Property Management acknowledged combustible materials were being stored less than five feet from a liquid oxygen container with a capacity greater than 3000 cubic feet. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2		monthly x6 months and Quarterly thereafter oruntil deemed unnecessary by Medical Director and or IDT Team. 5. DOC : 07/26/2013	

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	electrical wall fixtures in the oxygen storage and transfilling room was located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Director of Facilities and Property Management during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, two refrigerators were plugged into one electrical outlet which was located on the wall 12 inches (1 foot) above the floor and one light switch was located on the wall 54 inches (4 feet, 6 inches) above the floor. One liquid oxygen storage container which was three quarters full was observed stored in the room. Based on interview at the time of the observations, the Director of Facilities and Property Management acknowledged each of the			

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	aforementioned electrical wall fixtures were located on the wall less than five feet above the floor of the oxygen storage and transfilling room. 3.1-19(b)			

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K010143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Director of Facilities and Property Management, Staff Nurse #1 and Staff Nurse # 2 during a tour of the facility from 11:50 a.m. to 1:50 p.m. on 06/26/13, the entry door to	K010143	1.1. Removed Liquid Oxygen.. Relocated Liquid Oxygen to a outside storage area in a flameable cabinet with a locking door and proper signage.2. All residents,vistors and staff have the potential to be affected by this deficient practice. 3.Nursing Staff will check outside flameable cabinet after filling 02 portable tanks. Upon hire of maintenance oxygen / cabinet will check weekly during walking rounds. Executive Director will check Medication Room Quarterly to ensure no Oxygen Unit is stored. Oxygen Vendor will be instructed to leave no Oxygen in Medicication Room and to place into new cabinet outside on cement patio. Facility will maintain Oxygen Cylinders to	07/26/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E594	A. BUILDING 01 B. WING	06/26/2013

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	the oxygen storage and transfilling room by the Nurses Station had an affixed label stating it had a 20 minute fire resistance rating. In addition, one liquid oxygen storage container which was three quarters full was observed stored in the room. Based on interview at the time of the observations, the Director of Facilities and Property Management stated the ceiling of the oxygen storage and transfilling room had less than a one hour fire resistance rating and the door had less than a 45 minute rating, and acknowledged the oxygen storage and transfilling room did not provide separation of at least one hour fire resistive construction. Based on interview at the time of observation, Staff Nurse # 1 and Staff Nurse # 2 both stated oxygen transfilling does occur in the room. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 electrical wall fixtures in the oxygen storage and transfilling room were located at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary		be 3,000 cubic feet or less. Regional Maintenance Director will check for compliance upon visits to facility. Staff inserviced on citation 07/12/20134. Results to QA monthly x6 months and Quarterly thereafter oruntil deemed unnecessary by Medical Director and 5. DOC : 07/26/2013	

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	electrical wall fixtures in supply rooms shall be installed in fixed locations not less than five feet above the floor to avoid physical damage. This deficient practice could affect 24 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Director of Facilities and Property Management, Staff Nurse # 1 and Staff Nurse # 2, two refrigerators were plugged into one electrical outlet which was located on the wall 12 inches (1 foot) above the floor and one light switch was located on the wall 54 inches (4 feet, 6 inches) above the floor. One liquid oxygen storage container which was three quarters full was observed stored in the room. Based on interview at the time of the observations, the Director of Facilities and Property Management acknowledged each of the aforementioned electrical wall fixtures were located on the wall less than five feet above the floor of the oxygen storage and transfilling room. Based on interview at the time of observation, Staff Nurse # 1 and Staff Nurse # 2 both stated oxygen transfilling does occur in the room. 3.1-19(b)			

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K010144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating. b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all	K010144	1. The generator is programed to run, load, and exercise transfer switch every other Thursday at 1pm for 30 minute for a load test duration during a transitional period. 2. All residents / visitors and staff have the potential to be affected by this deficient practice. 3. Maintenance will obtain last date of last generator run and make a schedule to witness program function. . Data will be record into Life SafetyBook. Regional Maintenance Directorwill review data upon facility visits to ensure compliance of life safety code. Preventive Maintenance Program will be overseen by Regional Maintenance Director. Any concerns noted will be brought to the Executive Director. 4. Results to QA x6 months, Quarterly thereafter or until deemed unnecessary by Medical Director and or IDT Team. 5. DOC: 07/26/2013	07/26/2013

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	residents, staff and visitors. Findings include: Based on review of "MHCC Emergency Generator-Monthly Test Log" for 2012 and 2013 and Evapar's "Maintenance Order" documentation dated 05/16/13 with the Executive Director and the Director of Facilities and Property Management during record review from 9:40 a.m. to 11:50 a.m. on 06/26/13, documentation of a monthly load test for May 2013 was not available for review. The aforementioned documentation from Evapar stated "No transfer test performed" and the "MHCC Emergency Generator-Monthly Test Log" had no documentation for a monthly load test in May 2013. Based on interview at the time of record review, the Director of Facilities and Property Management stated Evapar was supposed to conduct the May 2013 monthly load test for the facility but acknowledged documentation of a May 2013 monthly load test was not available for review. 3.1-19(b)			